Washington State
Department of Social
& Health Services

Report to the Legislature

Final Implementation Report of the August 2002 JLARC Recommendations Regarding Children's Mental Health

RCW 71.36.050(1)

June 1, 2006

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EXECUTIVE SUMMARY

This report fulfills the Department of Social and Health Services (DSHS) statutory requirement (RCW 71.36.050) to submit a final implementation status report to the Governor and appropriate fiscal and policy committees of the legislature by June 1, 2006. The report provides details of tasks and activities undertaken by the department, with the assistance of the Office of the Superintendent of Public Instruction (OSPI) to implement the statutory requirements of RCW 71.36.046 to implement, within available resources, four of the Joint Legislative Audit and Review Committee (JLARC) Children's Mental Health Study recommendations.

1. Identify internal business operation issues that limit the agency's ability to meet legislative intent to coordinate existing categorical children's mental health programs and funding.

A number of initiatives have been undertaken towards improving cross systems collaboration within the department and between state agencies:

- Select Committee on Adolescents in Need of Long-Term Placement
- Treatment Foster Care Taskforce
- MHD/JRA development of cross systems protocols and transition agreements
- MHD/CA development of cross-system service delivery protocols
- DSHS Children's Mental Health Initiative

The September 2006-July 2007 Regional Support Networks (RSN) contract contains provisions for Allied System Plans between the Regional Support Networks and other child serving programs that include the implementation of cross-system planning for Early Periodic Screening Diagnosis and Treatment (EPSDT) children. The RSN contract describes the roles and responsibilities for Allied System coordination plans. There is a requirement that the coordination plans include a process for how the other systems will participate in the Individual Service Teams for multi-system Medicaid children under EPSDT. This attempts to assist the RSN's in facilitating the other systems participation in joint planning, though these other systems are not contractually required to do so.

The Children's Mental Health Initiative (CMHI) has represented a commitment on the part of DSHS and the assistant secretaries of Health and Recovery Services Administration, Children's Administration and Juvenile Rehabilitation Administration to provide better coordination and consider future integration of certain business practices for children and youth whose complex mental health and social needs go beyond the resources of one system to fully serve. This became an operational definition for the target population for CMHI, i.e. children and youth for whom mental health services are

being provided by two or more of the child serving systems, thereby constituting high-cost care and involving complex coordination challenges (Appendix 1-2).

CMHI leadership includes a director-level committee representing MHD, CA and JRA that is responsible for providing updates and making recommendations to the assistant secretaries of their respective administrations. Staffs from each administration have met to plan and coordinate both independent and joint efforts guided by the following vision of "improved mental health services for children and youth":

I. ***Services and supports are evidence-based and service providers are well trained in these practices.***
II. ***There is movement towards "integration of business services", including simplified access, joint contracts, and sharing of some system resources.***

III. ***The Department partners with tribes, minority communities and other interested parties to foster promising practices achievement of evidence-based practice status.***

IV. ***Family and stakeholder voice is valued and incorporated into planning.***

2. Collect reliable mental health cost, service, and outcome data specific to children. This information should be used to identify best practices and methods of improving fiscal management.

MHD has undertaken the following implementation efforts:

- Data dictionary revision
- Performance indicators
- Outcomes Measurement System
- Mental Health Costs - development of a cost database

Data Dictionary Revision: The data dictionary, MHD's published manual of data elements and definitions, has been reviewed and revised in meetings with RSNs, providers, and consumers. Service definitions have been revised to increase reporting consistency and assure compliance with the Health Insurance Portability and Accountability Act. Data dictionary revisions are included in the RSN contract.

Performance Indicators: MHD has incorporated 16 performance indicators into the annual Performance Indicator Report. The report has been published for four consecutive years.

Outcomes Measurement System: MHD has implemented a statewide outcome system for children and families served in the mental health system.

Mental Health Costs: The system is currently being modified to estimate costs for children's services alone.

Cross System Data Review: Three administrations, Health and Recovery Services Administration-Mental Health Division (HRSA-MHD), Children's Administration (CA) and Juvenile Rehabilitation Administration (JRA) reviewed service utilization patterns for a group of children who were high-utilizers of services across the three administrations. These analyses were the impetus for the creation of the Children's Mental Health Initiative (CMHI). Currently this initiative is focusing on implementing Evidence Based Practices for Children across the three administrations.
More recently the Department has convened a workgroup to analyze service utilization patterns and costs of children's mental health services across HRSA, CA, and JRA. This workgroup has begun to identify all mental health services across the three Administrations, and to classify them into large categories, such as outpatient, inpatient and residential services. Analysis, to be conducted by Research and Data Analysis (RDA), will identify service patterns, overlap, and costs associated with all children's mental health services. This data review will lead to the creation of a database that will allow for periodic assessments of children's mental health services within DSHS.

3. Revise the Early Periodic Screening Diagnosis and Treatment plan to reflect the mental health system structure in place on July 27, 2003, and thereafter revise the plan as necessary to conform to subsequent changes in the structure.

In December 2002, MHD and Medical Assistance (MA) updated the EPSDT plan in response to this JLARC recommendation. The updated plan was included in all of 14 of the 2003-2005 and is now included in the 2005-2006 RSN contracts with the MHD. It will be included in future iterations of the RSN contracts with the MHD. A report on the EPSDT plan revision was submitted to the Washington State Legislature on December 1, 2003 as required.

The September 06 to July 07 RSN contracts contain updated language that requires all Medicaid children that screen in as level 2 on the Access to Care Standards and are multi-system involved to be offered a cross-system Individual Service Team. This team will develop an Individual Treatment Plan that will identify not only what mental health services will be provided, but also how other identified needs will be addressed and what other system will be meeting the needs. This team is specific to the systems involved with that child.

Since the EPSDT plan is an integral part of the contracts between the RSNs and the MHD, the use of the EPSDT continues to be an expectation of the public mental health system in cooperation with Healthy Options physicians contracted by Medical Assistance. The updated plan simplifies and clarifies the use of EPSDT. The plan will be revised as necessary to conform to subsequent changes in the mental health system. In 2005, DSHS was reorganized to include both Mental Health Division and Medical Assistance within the Health and Recovery Services Administration. This reorganization has the potential to enable MHD and MA to collaborate even more closely and effectively on the implementation of the EPSDT plan.

4. **DSHS and OSPI should jointly identify school districts where mental health and education systems coordinate services and resources to provide public mental health care for children. DSHS and OSPI shall work together to share information about these approaches with other school districts, regional support networks, and state agencies.**

Collaboration between Department of Social and Health Services (DSHS) and the Office of Superintendent of Public Instruction (OPSI), begun in 2002 as a result of an interagency agreement and in response to the JLARC request, continues with joint meetings between MHD and OSPI staff on a bimonthly basis. A rubric (or matrix) was developed which identified the indicators and evidence of promising practices. The rubric was utilized to screen programs for selection to be interviewed. Interview questions were developed and used to conduct a follow-up contact of the twenty-two identified programs.

The information gathered provided activities for implementation of promising practices. These are presented in the accompanying grid. The grid displays the promising practices considered crucial to supporting students in receiving their education and mental health services and supporting their families. In addition, the grid displays indicators and activities which support the identified promising practices

DSHS/MHD and OSPI staff are aware of the possibility of additional programs around the state which have positive outcomes for students and their families which were not identified for this project. It is hoped that there will be continued efforts to identify these programs and add them to the list in the future. The list of programs implementing promising practices in the area of collaboration between schools and mental health agencies will be disseminated statewide through a variety of venues.

INTRODUCTION AND BACKGROUND

In 2001, the Washington State Legislature directed the Joint Legislative Audit and Review Committee (JLARC) to conduct a comprehensive children's mental health study. The purpose of the study was to review whether legislative intent was fulfilled regarding the coordination of children's mental health planning and services and the implementation of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. In addition, the study reviewed whether appropriate direction was available to the department in carrying out policy and management responsibilities based upon the 1991 children's mental health coordination statute.

JLARC produced its final report on the Children's Mental Health Study in August 2002. The report made five recommendations which were directed at streamlining and better integrating programs and services and increasing the systematic collection, analysis, and reporting of children's mental health service outcomes and costs. The Department of Social and Health Services (DSHS) concurred/partially concurred with the recommendations and the Mental Health Division (MHD) focused efforts on implementation.

The 2003 Legislature passed, and the Governor signed 2SHB 1784 (Chapter 281, Laws of 2003) supporting recommendations made in JLARC's 2002 study of the public mental health system for children. The legislation added two new sections to Chapter 71.36 RCW, coordination of children's mental health services. The new sections read as follows:

> RCW 71.36.040 – Issue identification, data collection, plan revision – coordination with other state agencies
>
> ***"****(1) The legislature supports recommendations made in the August 2002 study of the public mental health system for children conducted by the joint legislative audit and review committee.*
>
> *(2) The department shall, within available funds:*
> - *(a) Identify internal business operation issues that limit the agency's ability to meet legislative intent to coordinate existing categorical children's mental health programs and funding;*
> - *(b) Collect reliable mental health cost, service, and outcome data specific to children. This information must be used to identify best practices and methods of improving fiscal management;*
> - *(c) Revise the early periodic screening diagnosis and treatment plan to reflect the mental health system structure in place on July 27, 2003, and thereafter revise the plan as necessary to conform to subsequent changes in the structure.*
>
> *(3) The department and the office of the superintendent of public instruction shall jointly identify school districts where mental health and education systems coordinate services and resources to provide public mental health care for*

children. The department and the office of the superintendent of public instruction shall work together to share information about these approaches with other school districts, regional support networks, and state agencies."

RCW 71.36.050 – Report on implementation status

(1) In addition to any follow-up requirements recommended by the joint legislative audit and review committee, the department of social and health services shall submit a report to the governor and the legislature on the status of the implementation of the recommendations provided in RCW 71.36.040(2) (a) through (c) and, in coordination with the office of the superintendent of public instruction, on RCW 71.36.040(3). An initial implementation status report must be submitted to the governor and appropriate policy and fiscal committees of the legislature by June 1, 2004. A final report shall be provided no later than June 1, 2006.

STATUS OF IMPLEMENTATION EFFORTS

JLARC RECOMMENDATION 1 [RCW 71.36.040(1)(a)]:

Identification of cross-agency business operation issues

Identify internal business operation issues that limit the agency's ability to meet legislative intent to coordinate existing categorical children's mental health programs and funding;

A number of initiatives have been undertaken towards improving cross systems collaboration within the department and between state agencies:

- Select Committee on Adolescents in Need of Long-Term Placement
- Treatment Foster Care Taskforce
- MHD/JRA development of cross systems protocols and transition agreements
- MHD/CA development of cross-system service delivery protocols
- DSHS Children's Mental Health Initiative

Select Committee on Adolescents in Need of Long-Term Placement

Of significance is the establishment of a taskforce to study the highest need youth served by multiple systems within the department. This taskforce, known as the Select Committee on Adolescents in Need of Long Term Placement, was made up of community leaders and advocates, as well as DSHS administrators. The Committee published its final report in December 2002 making recommendations for improving the services and outcomes for youth with the highest need.

The MHD 2003-2005 contract with the RSNs includes a requirement for the RSNs to use treatment interventions that are research-based and shown to be effective in achieving positive outcomes when providing mental health services to children and youth. This requirement is the result of a recommendation of the Select Committee on Adolescents in Need of Long Term Placement.

Treatment Foster Care Taskforce

Acting on these recommendations, the DSHS Children's Administration (CA) formed the Treatment Foster Care Taskforce. This taskforce met during 2003 to review the foster care system. It made recommendations of the type of foster care and treatment most likely to be effective and beneficial with high need youth in the foster care system. The final report is in draft form only and has not been published.

MHD/JRA Development Of Cross Systems Protocols and Transition Agreements

MHD and the Juvenile Rehabilitation Administration (JRA) worked together to develop cross systems protocols and transition agreements between each of the Regional Support Networks (RSN) within the public mental health system and each of the corresponding JRA regions. These agreements, completed in 2003, facilitate a smooth transition from JRA facilities to the community for youth who have mental health diagnoses.

MHD/CA Development of Cross Systems Protocols and Dispute Resolution Agreement

MHD included in its 2001-2003 contracts with the RSNs, a requirement that each RSN develop cross-system service delivery protocols for the coordination and integration of services with each of the DSHS CA Regions. Protocols were completed in October 2003 and presented at a December 2003 joint meeting of the RSN Administrators and CA Regional Administrators attended by the Assistant Secretaries of the Health and Rehabilitative Services Administration (HRSA), CA and JRA. The 2003-2005 RSN contracts with the MHD include a requirement that the RSN implement these protocols. In addition, a Dispute Resolution Agreement between MHD and CA was finalized after meetings which included input from the RSNs, CA regions and DSHS headquarters staff.

SAMHSA Planning Grant Received for the Implementation of Evidence-based Practices

In October 2003, the MHD received a Federal Substance Abuse and Mental Health Services Administration (SAMHSA) planning grant for the development of the use of evidence-based practices. Efforts to identify and plan for the implementation of evidence-based practices (EBPs) are underway with a workgroup consisting of service systems stakeholders.

Children's Mental Health Initiative

The Children's Mental Health Initiative (CMHI) grew out of DSHS leadership's commitment to improve care delivery and provide better coordination of services for children and youth with complex mental health and social needs. The target population, defined as children and youth receiving mental health services from two or more of the

child serving systems (MHD, CA, JRA), constitutes a high-cost category and is characterized by coordination challenges. (Appendix 1-2)

A director-level committee provides leadership for CMHI and is responsible for providing updates and making recommendations to the assistant secretaries of HRSA/MHD, CA and JRA. This committee discusses current administration- specific progress in the implementation of evidence-based practices and coordinates joint efforts (currently the EBP Matching Tool). These efforts are guided by the shared objective of improved mental health services for the highest need youth and the following guiding principles or strategies that evolved during cross-system project team meetings held in 2004 and 2005:

I. Services and supports are evidence-based and service providers are well trained in these practices.

II. There is movement towards "integration of business services", including simplified access, joint contracts, and sharing of some system resources.

III. The Department partners with tribes, minority communities and other interested parties to foster promising practices achievement of evidence-based practice status.

IV. Family and stakeholder voice is valued and incorporated into planning.

Progress:

I. Implementation of Evidence-Based Practices

Many mental health practices and therapy interventions have been studied to determine how effectively they impact the lives of children, youth, and families. Within the child/youth populations served by DSHS, effective practices result in improved mental health and better functioning at home and school; increased likelihood of staying at home or being in a stable placement; avoidance of higher cost and more restrictive levels of care such as children's long-term inpatient treatment, and reduced levels of juvenile crime.

The current work of CMHI includes implementation of five EBPs:

- Multidimensional Treatment Foster Care (MTFC)
- Functional Family Therapy (FFT)
- Trauma-focused Cognitive Behavioral Therapy (TF-CBT)
- Family Integrated Transitions (FIT)
- Multi-System Therapy (MST)

DSHS CMHI chose these EBPs on the basis of the recommendations of an "expert panel" of researchers from across the state. These practices range from institutional and out of

home (treatment foster care) to community and home-based interventions all designed to avoid placement or placement disruption and reduce the need for chronic and/or institutional care (Appendix 3).

To date, progress includes:

- The expansion of MTFC, to include 30 additional treatment foster care beds for the Children's Administration and 10 treatment foster care beds (one site) for youth with primary mental illness and behavioral disorders in the Mental Health System.

- TFCBT training through a partnership with the University of Washington and the national developers of the model. The training in 2006 was attended by providers in 9 of 13 Regional Support Networks and two Indian Nations. The curriculum consisted of organizational readiness consultation, clinical practice training, web-based support and ongoing consultation groups for teams from 19 community and tribal mental health providers. A second "cohort" for this training is being planned for 2007.

- Early discussion among MHD, JRA and DASA about expanding implementation of FIT for youth with co-occurring substance abuse and mental health disorders in facility and community based care. This will likely mean additional contracting by the Department with FIT model developers at the University of Washington, Division of Public Behavioral Health and Justice.

- Expansion of Functional Family Therapy through Children's Administration, which has previously been available only within JRA.

- A children's mental health track with emphasis on evidence-based practices for youth sponsored by the Mental Health Division at the annual Washington Behavioral Healthcare Conference. This track covered issues and implementation dilemmas related to EBPs for children of color, childhood trauma, and co-occurring disorders.

Additionally, the 2006 Legislative Budget included an allocation of $450,000 to support, study and implement an evidence-based program pilot addressing the mental health needs of youth. The contract for this pilot , as determined by a DSHS procurement is in the process of negotiation with the apparently successful bidder. Community needs assessment, planning, choice of an EBP and implementation will be supported by the University of Washington Division of Public Behavioral Health and Justice. This pilot will be operational by December 2006 and will be evaluated by the Washington State Institute on Public Policy (WSIPP).

II. Integration of business practices.

CMHI is developing an instrument with the assistance of WSIPP that will be used by all three administrations to match children and youth to the appropriate evidence-based practice or practices. This domain-based tool will be modeled upon WSIPP's Washington State Juvenile Court Assessment and will create the foundation for prospective cross system efficiencies to be employed in assessment and case-management.

III. Tribal and Minority Collaboration

Two forums have been held with researchers and providers representing diverse ethnic, minority and tribal groups that have addressed the perceived effectiveness and cultural relevance of EBPs. Discussion includes the exploration of potential funding strategies to support the evolution of "promising practices", particularly those in use by tribes and minority communities, into "evidence-based practice" status.

IV. Family and stakeholder voice

The Department is involving parents and families to share information and invites stakeholder input through:

- Forums with families and youth
- Contracting with Statewide Action for Family Empowerment of Washington (SAFE-WA) to orient parents to the 5 chosen evidence-based practices
- Potential creation of a Parent/Family Advisory Group

The Secretary of DSHS has directed the assistant secretaries to support the project and ensure accountability and ongoing partnership. MHD updates and has obtained input from the children's subcommittee of its Mental Health Planning and Advisory Council (MHPAC) and coordinates with the Mental Health Transformation Grant.

Outside of CMHI, but evidencing coordination among administrations, the Division of Substance Abuse (DASA) received a coordination grant from SAMHSA-Center for Substance Abuse Treatment (CSAT) to develop a statewide infrastructure that fosters cross system planning, knowledge and resource sharing to enhance the existing adolescent substance abuse treatment system. The Mental Health Division, Children's Administration and Juvenile Rehabilitation Administration participate on the Statewide Leadership Council and subcommittees of this grant chartered to address resource gaps and improve licensing and certification standards, training in evidence-based practices and treatment integration through cross system collaboration.

JLARC RECOMMENDATION 2 [RCW 71.36.040(2) (b)]
Mental health cost, service and outcome data specific to children
Collect reliable mental health cost, service, and outcome data specific to children. This information must be used to identify best practices and methods of improving fiscal management;

MHD has undertaken the following implementation efforts:

- Data dictionary revision
- Performance indicators
- Outcomes Measurement System
- Mental Health Costs - development of a cost database

MHD, in partnership with Children's Administration and Juvenile Rehabilitation Administration, has undertaken the following implementation effort:

- Cross system data review

Data Dictionary Revision: The data dictionary, MHD's published manual of data elements and definitions, has been reviewed and revised in meetings with RSNs, providers, and consumers. Service definitions have been revised to increase reporting consistency and assure compliance with the Health Insurance Portability and Accountability Act. Data dictionary revisions are included in the RSN contract. MHD has included these definitions on its website where providers and clinicians have easy access. The web site lists all data elements reported by providers, definitions, and codes. It provides training on rating scales, lists frequently asked questions, and directs additional questions to MHD for response.

Performance Indicators: MHD has incorporated 16 performance indicators into the annual Performance Indicator Report. The report has been published for four consecutive years and includes the following indicators:

1. Penetration rates for services by race/ethnicity, age, gender, and Medicaid eligibility
2. Utilization rate for services by race/ethnicity, age, gender, and priority population
3. Recipient perception of access
4. Recipient perception of quality/appropriateness of services
5. Recipient perception of active participation in decision making regarding treatment
6. Percentage of service recipients who are employed
7. Average annual cost per recipient served
8. Average annual cost per unit of service; cost per hour for community services
9. Percent of revenues spent on direct services
10. Percent of recipients who were homeless in the last 12 months by age and priority population
11. Percent of children who live in "family-like" settings
12. Percent of children and adolescents receiving services in natural settings outside of a clinician's office
13. Percent of recipients who are maintained in the community without a psychiatric hospitalization during the last 12 months
14. Percent of recipients who receive services by both MHD and the Division of Alcohol and Substance Abuse (DASA) in the previous 12 months
15. Percent of consumers who access physical healthcare
16. Percent of service recipients living in stable environments

Outcomes Measurement System: MHD has implemented a statewide outcome system for children and families served in the mental health system. The outcome system measures children at various points during treatment on the following variables: functioning, school performance, legal problems, living situation, quality of life and social interactions. The system has been implemented statewide. Currently, over 17,000 children and families have been surveyed.

Mental Health Costs: MHD developed a cost database that estimates costs for each category of mental health service delivered. Estimated costs for children's Mental Health Services can be derived from this database.

Cross System Data Review: Three administrations, Health and Recovery Services Administration-Mental Health Division (HRSA-MHD), Children's Administration (CA) and Juvenile Rehabilitation Administration (JRA) reviewed service utilization patterns for a group of children who were high-utilizers of services across the three administrations. These analyses were the impetus for the creation of the Children's Mental Health Initiative (CMHI). Currently this initiative is focusing on implementing Evidence Based Practices for Children across the three administrations.

More recently the Department has convened a workgroup to analyze service utilization patterns and costs of children's mental health services across HRSA, CA, and JRA. This workgroup has begun to identify all mental health services across the three Administrations, and to classify them into large categories, such as outpatient, inpatient and residential services. Analysis, to be conducted by Research and Data Analysis (RDA), will identify service patterns, overlap, and costs associated with all children's mental health services. This data review will lead to the creation of a database that will allow for periodic assessments of children's mental health services within DSHS.

JLARC RECOMMENDATION 3 [RCW 71.36.040(2) (c)]

EPSDT plan revision

Revise the early periodic screening diagnosis and treatment plan to reflect the mental health system structure in place on July 27, 2003 and thereafter revise the plan as necessary to conform to subsequent changes in the structure.

In December 2002, MHD and Medical Assistance Administration (MAA) updated the EPSDT plan in response to this JLARC recommendation. The updated plan was included in all 14 of the 2003-2005 and is now included in the 2005-2006 RSN contracts with the MHD. It will be included in future iterations of the RSN contracts with the MHD. A report on the EPSDT plan revision was submitted to the Washington State Legislature on December 1, 2003 as required.

Since the EPSDT plan is an integral part of the contracts between the RSNs and the MHD, the use of the EPSDT continues to be an expectation of the public mental health system in cooperation with Healthy Options physicians contracted by Medical Assistance. The updated plan simplifies and clarifies the use of EPSDT. The plan will be revised as necessary to conform to subsequent changes in the mental health system. In 2005, DSHS was reorganized to include both Mental Health Division and Medical Assistance within the Health and Recovery Services Administration. This reorganization has the potential to enable MHD and MA to collaborate even more closely and effectively on the implementation of the EPSDT plan.

The September 06 to July 07 RSN contracts contain updated language that requires all Medicaid children that screen in as level 2 on the Access to Care Standards and are multi-system involved to be offered a cross-system Individual Service Team. This team will develop an Individual Treatment Plan that will identify not only what mental health

services will be provided, but also how other identified needs will be addressed and what other system will be meeting the needs. This team is specific to the systems involved with that child. The contract additionally contains provisions for Allied System Plans between the Regional Support Networks and other child serving programs that include the implementation of cross-system planning for EPSDT children.

The department had convened an EPSDT Improvement Team to address ongoing issues with the use of EPSDT plans. EPSDT Improvement Team meetings provide the opportunity for input, discussion of issues and sharing of information and coordination by representative of Medical Assistance Healthy Option Plans, the Washington State Department of Health (DOH), DSHS Children's Administration, Medical Assistance and the Mental Health Division, other cross systems partners and the Centers for Medicare and Medicaid Services (CMS). These quarterly meetings continue and provide a valuable venue for information sharing and problem solving.

JLARC RECOMMENDATION 4 [RCW 71.36.040 (3)]

Coordination with OSPI to identify and disseminate models of best practices

The department and the office of the superintendent of public instruction shall jointly identify school districts where mental health and education systems coordinate services and resources to provide public mental health care of children. The department and the office of the superintendent of public instruction shall work together to share information about these approaches with other school districts, regional support networks, and state agencies.

Collaboration between Department of Social and Health Services (DSHS) and the Office of Superintendent of Public Instruction (OPSI), begun in 2002 as a result of an interagency agreement and in response to the JLARC request, continues with joint meetings between MHD and OSPI staff on a bimonthly basis. Activities that were reported in *2004 Status of Implementation of the August 2002 JLARC Recommendations Regarding Children's Mental Health* included the research that identified four components of successful programs and a survey that was developed and conducted in late 2003. A preliminary analysis identified twenty-two (22) programs warranting follow-up interviews to determine if they met the criteria for selection as programs implementing promising practices in coordinating services between local school districts and public mental health agencies.

A rubric (or matrix) was developed which identified the indicators and evidence of promising practices. The rubric was utilized to screen programs for selection to be interviewed. Interview questions were developed and used to conduct a follow-up contact of the twenty-two identified programs (Appendix 4). To the extent possible, the identified agencies and districts were interviewed for the purpose of understanding the various aspects of their programs. The information gathered provided activities for implementation of promising practices. These are presented in the accompanying grid. The grid displays the promising practices considered crucial to supporting students in receiving their education and mental health services and supporting their families. In addition, the grid displays indicators and activities which support the identified promising practices (Appendix 5).

The programs which demonstrate promising practices are listed by school districts and Regional Support Network (RSN) and the Community Mental Health Agency (CMHA) they are associated with, as appropriate. RSNs are county-based local mental health authorities that contract with the DSHS Mental Health Division to administer the public mental health system. RSNs contract with local CMHAs to provide the public mental health services in the local community. It should be noted that since public mental health agencies are expected to provide counseling services in the school setting when indicated, this was considered to be business as usual rather than a promising practice in and of itself. The list of programs representing promising examples of coordination between public schools and public mental health is not exhaustive (Appendix 6). To assist in locating the programs around the state, a map was created identifying the location of each program (Appendix 7).

DSHS/MHD and OSPI staff are aware of the possibility of additional programs around the state which have positive outcomes for students and their families which were not identified for this project. It is hoped that there will be continued efforts to identify these programs and add them to the list in the future. The list of programs implementing promising practices in the area of collaboration between schools and mental health agencies will be disseminated statewide through a variety of venues.

The dissemination plan includes presentations at the 12th Annual OSPI Community Collaboration Conference on March 23rd 2006 and at the Washington Behavioral Healthcare Conference on June 15th 2006. The tools such as the interview questions and the rubric (or matrix) will be posted on each agency's website and also sent out to the OSPI and DSHS/MHD appropriate distribution lists. Plans are under way to present this material at the OSPI summer institutes, to the RSN's Children's Care Managers and to the Children's Subcommittee of the Mental Health Planning and Advisory Council (MHPAC). It will be presented at other appropriate venues whenever the opportunities arise.

The information gathered in this collaborative project will be provided to the Mental Health Transformation Work Group and the Children, Youth and Families Subcommittee on which OSPI sits. In this way, what has been learned in this effort will inform the transformation process of the mental health system. The Mental Health Transformation, under the auspices of Governor Christine Gregoire, is funded by a five year federal grant, $2.73 million dollars per year beginning in 2005, from the Substance Abuse and Mental Health Services Administration. The goal is to re-imagine and re-create the mental health system in Washington State with the voices of consumers of all ages, their families and their advocates, at the center of this transformation process.

Collaboration between OSPI and DSHS/MHD continues not only with regard to the identification and dissemination of information about these promising practices but also in the involvement of OSPI as a standing member on both the Mental Health Planning and Advisory Council (MHPAC) and the Children's Subcommittee of the MHPAC, which advise the Mental Health Division. The interagency agreement and program agreement both ensure ongoing collaborative efforts between the two agencies.

CONCLUSION

DSHS remains committed to ensuring that the mental health needs of Washington State's children are met within a coordinated and comprehensive framework. The department has continued to make progress towards implementation of the four JLARC Children's Mental Health Study recommendations for:

- improved business practice coordination and collaboration,
- collection of reliable data for children's services,
- revising the early periodic screening diagnosis and treatment plan, and
- coordinating with the Office of the Superintendent of Public Instruction.

The Children's Mental Health Initiative, a joint project with Children's Administration, Juvenile Rehabilitation Administration and the Mental Health Division, is moving forward with the implementation of evidence-based practices, and the joint project between MHD and OSPI has been a fruitful effort that lays the groundwork for ongoing collaboration between the two agencies.

Web links:
http://www1.dshs.wa.gov/pdf/ea/CMHIoverview.pdf
http://www1.dshs.wa.gov/WorkingTogether/MHGroup.html
http://www1.dshs.wa.gov/word/ea/EBPExpertPanel.doc

Appendix 1: Overview of the Children's Mental Health Initiative

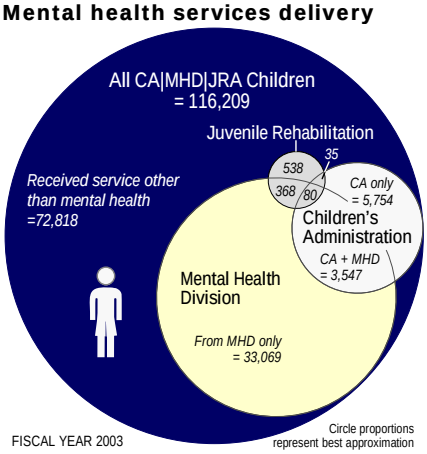
Overview of the Children's Mental Health Initiative

Effective Therapy Interventions for Kids and Families

Children and youth with mental health needs are served by many programs operated or funded by DSHS. Many mental health practices, including therapy interventions, have been studied nationally and in our state to determine how effectively they impact the lives of children, youth, and families. Effective practices result in improved mental health and better functioning at home and school; increased likelihood of staying at home or being in a stable placement; and reduced levels of juvenile crime. DSHS wants more children, youth, and families to have the opportunity to receive therapies that have been proven to be effective and that will better serve youth with multiple complex needs. Thus, DSHS has created the Children's Mental Health Initiative (CMHI) to coordinate delivery across three DSHS programs – Mental Health, Children's (child welfare), and Juvenile Rehabilitation. The data below sets the stage for CMHI strategies by demonstrating need.

Children and youth now receive mental health services throughout DSHS

Mental health services delivery



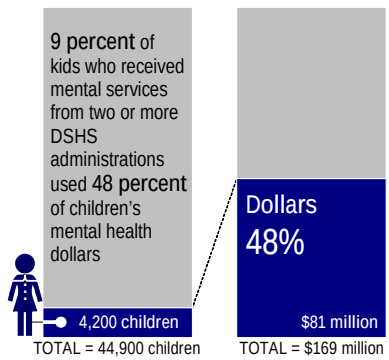
- Coordination is difficult for kids who need mental health services from two or more administrations.
- Of the 116,209 served by CA, JRA, and|or MHD in Fiscal Year 2003 (smaller circles), **37 percent of the combined caseload** (43,391 children) **received mental health services**.
- About **9 percent** (4,030) **of these children and youth** received mental health services from two or more administrations:

3,547	From CA and MHD
368	From JRA and MHD
35	From CA and JRA
80	From CA, MHD, and JRA

9 percent of kids used half of the mental health dollars for all kids

A few use half of the dollars

DSHS Expenditure, FY 2002

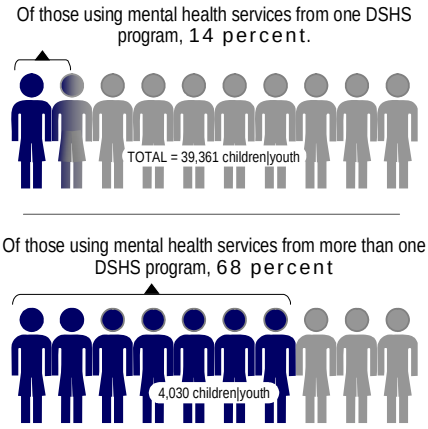


- In Fiscal Year 2002, over **126,000** children and youth received services from three DSHS programs: CA, JRA, and|or MHD.
- **44,900** of these children and youth received at least one mental health service from one of the systems during that year.
- Collectively, the mental health services for those 44,900 young people **cost $169 million**.
- **Half of that expenditure** ($81 million) was spent on the **9 percent** who received mental health care from two or more programs.

Children and Youth with Mental Health Needs

Receiving treatment or placement away from home sometime during year

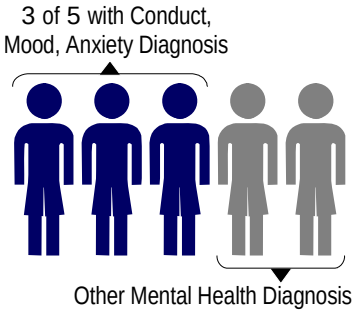
How many treated or placed away from home at some point in 2003?



- In 2003, of the **39,361 children** and youth who used mental health services one program (CA, JRA, or MHD), **14 percent** spent some time in treatment or placement away from home.
- In 2003, of the **4,030 children** who used mental health care from two or three administrations, **68 percent** spent some time in treatment or placement away from home.
- Typically, those spending time away from home are in foster care, inpatient or residential treatment, or a JRA institution.

Conduct, mood, and anxiety issues frequent for those with complex needs

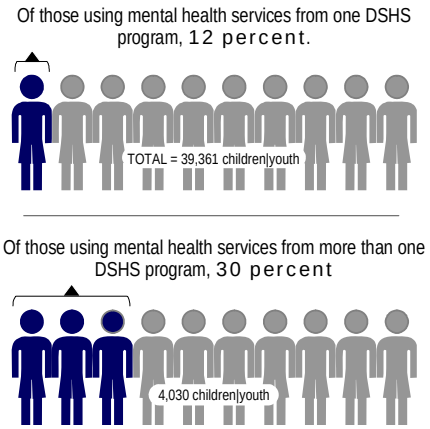
Conduct disorders most frequent
Highest Need 4,030 Children and Youth, FY 2003



- **Conduct, mood, and anxiety disorders** are the most common diagnoses among the 4,030 youth with complex needs – three of five have these diagnoses.
- Among the 4,030 children/youth with complex needs:
  - Seven out of ten are **teenagers.**
  - Six out of ten are **male.**
  - Three out of ten are a minority race or ethnicity.

Juvenile justice involvement

How many have been convicted of a misdemeanor or felony?

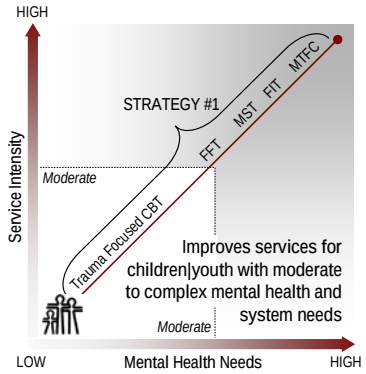


- Of the **39,361 children** and youth who used mental health services from one program (CA, JRA, or MHD), **12 percent** have been convicted of a misdemeanor or felony at some time in their life.
- Of the **4,030 children** who used mental health care from two or three programs, 30 percent have been convicted of a misdemeanor or felony at some time in their life.

NOTE: These criminal justice data are drawn from the WSIPP Criminal Recidivism Database, augmented by JRA records. The percentages are probably an underestimate.

Implementing Strategies That Help Children and Youth

STRATEGY 1: Introduce and expand use of Evidence Based Practices

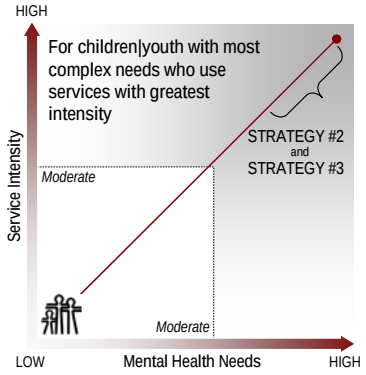


Evidence Based Practices (EBPs) are shown to **result in positive school, home, and community outcomes** for children and youth with mental health needs.

Strategy 1 establishes:

- Common quality assurance, adherence, monitoring protocols, plus incentives that support use of EBPs, across all three administrations.
- Common referral to jointly administered approach for children|youth.

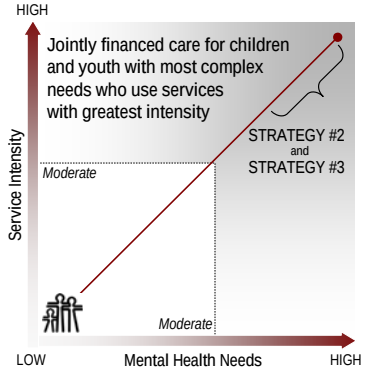
STRATEGY 2: Coordinated care for children and youth with complex needs



Components of Strategy 2 include:

- A shared assessment tool.
- Coordinated care planning.
- Coordinated service delivery.
- Expanded parent and youth voice.
- A single-lead case manager for the children, youth, and families with the most complex needs.
- Shared standards for services across DSHS programs – agreement on EBPs applied.

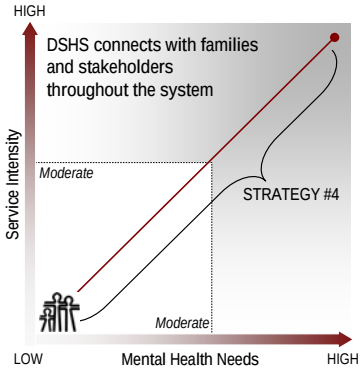
STRATEGY 3: Jointly manage and finance care for kids with complex needs



Strategy 3 in concept:

- Note that further development of strategy 3 will occur after significant development of Strategy 1.
- It is expected we will pool funding resources.
- And modify service and financing infrastructure as needed to effect change throughout the system.

STRATEGY 4: Connect with families and stakeholders through ongoing plan

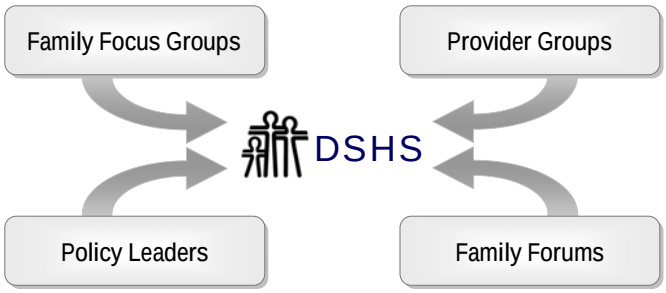


Strategy 4 applies across the entire children's mental system and:

- Involves families, advocates, and providers in implementation planning to include family forums and focus groups.
- Shares information about best practices and builds support for the use of EBPs.
- Assures formal feedback mechanisms through stakeholder meetings and routine updates.

Seeking Family, Youth and Stakeholder Input

Strategy 4 of the DSHS Children's Mental Health Initiative will involve ongoing efforts to inform and hear from families, youth, and stakeholders regarding the implementation of the Children's Mental Health Initiative Strategies. A family focus group was held in Western Washington in May, and a family forum in Eastern Washington in June 2005.



Next Steps

Strategies Toward Effective Therapy Interventions

The Children's Mental Health Initiative will be implemented using the strategies identified on the previous page. All CMHI strategies support families, children, and youth to build strong, productive relationships. Our work recognizes the role of parents and their right to make choices that benefit their child and family. We believe that the services we introduce through this effort will add valuable options for parents to consider.

An Evaluation Design and Lessons Learned

A common plan for monitoring and evaluating of the initiative and its component EBPs is under development. It will track and describe the set of young people and families involved in each EBP, and monitor changes in enrolled children during and right after treatment. Later, it will address program impacts by comparing enrolled children with similar children receiving customary treatment, and assessing changes in outcomes during a year or two following treatment. When possible, the monitoring and evaluation plan will use administrative data.

Child life changes addressed in the evaluation will include functioning, self-reported quality of life, problem behavior, clinical status, substance abuse, injuries, accidents, arrests, and convictions. School grades and school problems will be obtained if possible. Service use changes include days in restrictive settings and out-of-home placements, overall DSHS service costs per client and per family, and intensity of services provided.

CONTACT **Dave Hogan**
Children's Mental Health Initiative Director
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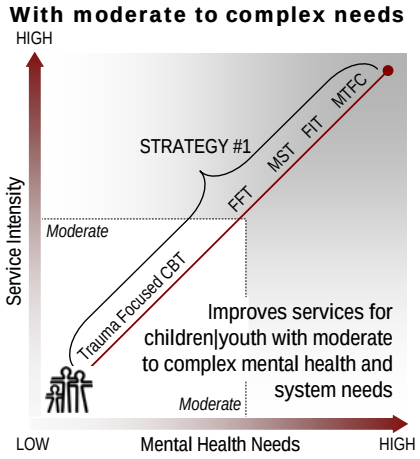
STRATEGY 1 | Introducing and Expanding Use of Evidence Based Practices (EBPs)

Goal: Achieve Better Outcomes for Kids and Families

Children and youth with mental health needs are served by many programs operated or funded by DSHS. Many mental health practices, including therapy interventions, have been studied nationally and in our state to determine how effectively they impact the lives of children, youth, and families. Effective practices result in improved mental health and better functioning at home and school; increased likelihood of staying at home or being in a stable placement; and reduced levels of juvenile crime. DSHS wants more children, youth, and families to have the opportunity to receive therapies that have been proven to be effective and that will better serve youth with multiple complex needs. Thus, DSHS has created the Children's Mental Health Initiative (CMHI) to coordinate delivery across three DSHS programs – Mental Health, Children's (child welfare), and Juvenile Rehabilitation. This handout summarizes the plan for Strategy 1: Implementing Evidence Based Practices (EBPs).

Effective Therapy Interventions for Kids and Families



CMHI Strategy 1 expands and jointly administers a set of Evidence Based Practices. These research-based practices improve child, youth and family functioning, increase stability of care, decrease crisis-driven out-of-home placement, and reduce crime.

Strategy 1 establishes:

- A consistent set of EBPs that will improve outcomes common to all three administrations.
- Common quality assurance, adherence, training, monitoring and evaluation protocols
- Incentives to support use of these EBPs across all three administrations, for both shared clients and for children seen only in one administration.

Evidenced Based Practice Selection Criteria

Does the Evidenced Based Practice?

Yes	No	
☑	☐	Address common diagnoses (conduct, mood, anxiety, PTSD, and ADHD).
☑	☐	Improve common system outcomes (reduces out-of-home placement, care crises, instability and arrests).
☑	☐	Come well packaged and robust.
☑	☐	Apply cross-culturally.
☑	☐	Fit into the continuum of care.

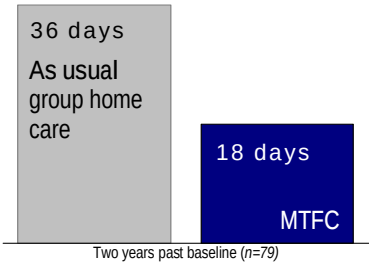
Strategy 1 EBP process:

- **Fall 2004:** Expert Panel recommended set of EBPs for CMHI to consider.
- **Winter 2005:** Staff workgroup recommended five EBPs for initial implementation. In some cases, existing examples of EBPs will be expanded; in other cases, new EBPs will be added.
- **Spring 2005:** Planning and feedback on the CMHI.
- **July 2005:** Implementation begins.

The Agreed Upon Evidenced Based Practices

Multidimensional Treatment Foster Care (MTFC)

MFTC reduces "days on the run"



Journal of Emotional and Behavioral Disorders, Spring 2004.

PROPOSAL

IMPROVED OUTCOMES: Increases placement stability and successful family reintegration, and reduces arrests and convictions.

TARGET DISORDERS: Oppositional Defiant and|or Conduct Disorder, and substance abuse.

ELIGIBILITY: Child|youth meets community JRA standards, CA Level 1A or 1B BRS, mental health diagnosis, or is being diverted from CA Long-term Inpatient Program (CLIP).

AGE: 10-18 year olds and family members.

SETTING: Out-of-home care with family participation during care or outpatient.

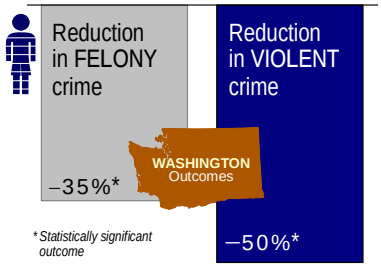
COST: Per Diem rates $161 per day.

MODEL OVERVIEW

- MTFC is a cost-effective alternative to group care for adolescents with problems with chronic antisocial behavior, emotional disturbance, and delinquency.
- Community foster families are recruited and closely trained to provide adolescents with: treatment and intensive supervision at home, in school, and in the community; clear and consistent limits and follow through on consequences; positive reinforcement for appropriate behavior, a relationship with a mentoring adult, and separation from antisocial peers.
- Weekly individualized therapy and group meetings are integral components and a program monitor maintains daily contact with the foster parents.
- Biological or placement families actively participate in the treatment, learning effective parenting skills, and preparing for the child|youth's return home.
- MTFC is recommended as a cost-effective model by the Washington State Institute for Public Policy, is a Blueprint Program from the Center for the Study of Prevention of Violence, and is an Effective SAMSHA Model Program.

Functional Family Therapy (FFT)

FFT reduces arrests



PROPOSAL

IMPROVED OUTCOMES: Increases placement stability and family placement and reduces arrest and convictions.

TARGET DISORDERS: Oppositional Defiant and|or Conduct Disorder, Disruptive Behavior Disorder

ELIGIBILITY: High need multi-system child|youth, FRS Phase II, family is in conflict, low level of family engagement, long history of failure in other systems, at risk to commit crimes, and family therapy is indicated.

AGE: 10-18 year olds and family members

DURATION: Average 15 service hours (10-30)

SETTING: In-home or out-patient with biological, adoptive, or long-term foster family and substance abuse.

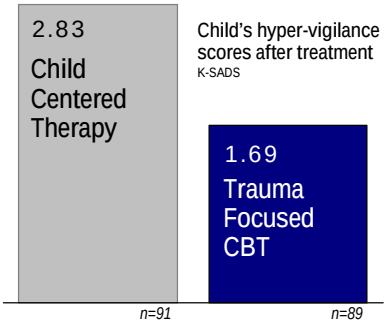
COST: Per Diem rates $35 per day.

MODEL OVERVIEW

- FFT is a prevention|intervention program for at-risk adolescents and their families, including a specific focus on younger siblings.
- FFT is a short-term intervention – on average 8 to 12 sessions and up to 30 hours of direct services for more complex situations. It is based on established clinical theory and practice.
- Treatment phases include youth and family engagement and motivation, behavior change, and generalization.
- Although commonly used as an intervention program, FFT is also an effective prevention program for at-risk adolescents and their families. Whether implemented as an intervention or a prevention program, FFT may include diversion, probation, alternatives to incarceration, and|or reentry programs for youth returning to the community following release from an institutional setting.
- FFT is recommended as a cost-effective model by the Washington State Institute for Public Policy and is a Blueprint Program from the Center for the Study of Prevention of Violence.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT)

Post Traumatic Stress Disorder Symptoms



Journal of Counseling and Clinical Psychology.

PROPOSAL

IMPROVED OUTCOMES: Decreases Post Traumatic Stress Disorder (PTSD) symptoms in the children, and depression and anxiety in the parents.

TARGET DISORDERS: PTSD, depression, anxiety and behavior problems associated with trauma.

ELIGIBILITY: Any child or youth who has experienced trauma and is exhibiting PTSD, depression, emotional distress, behavior problems, or sexualized behaviors.

AGE: 3-18 year olds with family in some sessions

DURATION: 12 sessions in 2 months.

SETTING: Outpatient.

COST: $240 per week.

MODEL OVERVIEW

- Trauma Focused CBT targets children who have experienced trauma due to sexual and physical abuse, death, and witnessing violence. Both children and their parents are involved in the therapy sessions.
- TF-CBT is an outpatient model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy.
- TF-CBT is based in established theory and practice. With TF- CBT, children and parents learn skills related to addressing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication.
- TF-CBT is useful for children|youth all along the continuum of care.
- TF-CBT is recommended as a "Well Supported and Efficacious" program by the National Child Traumatic Stress Network.

Family Integrated Transitions (FIT)

Each dollar invested in FIT saves three

Washington State Institute for Public Policy, December 2004

Savings indicates life cycle costs -- saved to victims and criminal justice system

PROPOSAL

IMPROVED OUTCOMES: Reduces arrests and convictions.

TARGET DISORDERS: Substance abuse and|or dependence and a DSM IV Axis 1 diagnosis.

ELIGIBILITY: Youth with substance abuse and|or dependency disorder and Axis 1 disorder, and are scheduled to be released from either a JRA institution, Level 1A or 1B BRS placement or CLIP facility.

AGE: 11-17 year olds and family members.

DURATION: Typically 6 months.

SETTING: In-home and community.

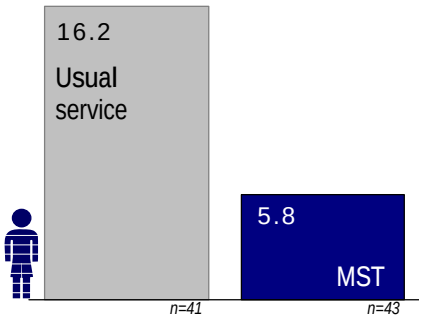
COST: Typical Per Diem rates $50 per day.

MODEL OVERVIEW

- FIT targets youth with both mental illness and alcohol|drug problems, who are leaving a residential facility to return to community life. Both youth and their families are involved
- FIT uses an intensive home- and community-based model of service delivery beginning in a residential setting, then continuing four to six months in the community. It is an intensive outpatient model.
- FIT combines elements of four proven therapeutic approaches – MST, Motivational Enhancement Therapy, Relapse Prevention, and Dialectal Behavior Therapy – in an integrated model designed to address the unique needs of teenagers with both mental illness and chemical dependency.
- The Washington State Institute for Public Policy has found that FIT reduces felony recidivism among these youth. Therefore, the Institute recommends it as a cost-effective model.

Multi-Systemic Therapy (MST)

MST means less time away from home



Journal of Consulting and Clinical Psychology, 1992.

PROPOSAL

IMPROVED OUTCOMES: Increases family cohesion, and reduces aggressive behavior, arrests, and convictions.

TARGET DISORDERS: Chronic, violent, substance abusing youth.

ELIGIBILITY: Serious juvenile offender at high risk for out-of-home placement, youth at risk of Children's Long-term Inpatient Program or Behavior Rehabilitation Services placement.

AGE: 10-18 year olds and family members.

DURATION: Range of four months.

SETTING: Community based.

COST: Per Diem rates $58 per day.

MODEL OVERVIEW

- MST targets chronic, violent, or substance-abusing youth, ages 12 to 17, at high risk of out-of-home placement – and their families.
- MST uses an intensive home- and community-based model of service delivery. On average, youth and family experience 60 hours of contact over four months.
- MST works to empower both youth and parents, through support and skill building designed to:
- Equip parents with the skills and resources needed to address the problems of raising teenagers
- Help youth develop the skills needed to cope with family, peer, school, and neighborhood problems.
- MST has been proven effective with families from a range of socioeconomic and ethnic backgrounds. The impact of the program on African-American and Hispanic youth has been well-studied.
- MST is recommended as a cost-effective model by the Washington State Institute for Public Policy and is a Blueprint Program from the Center for the Study of Prevention of Violence.

Next Steps

Four Strategies Toward Effective Therapy Interventions

The Children's Mental Health Initiative will be implemented using the four strategies, all of which are designed to support families, children, and youth to build strong, productive relationships. Our work recognizes the role of parents and their right to make choices that benefit their child and family. We believe that the services we introduce through this effort will add valuable options for parents to consider.

CONTACTS

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Report of the Children's Evidence Based Practices Expert Panel

Submitted to DSHS-
Children's Administration,
Juvenile Rehabilitation Administration,
Mental Health Division

February 11, 2005

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Introduction

This expert panel was convened by the Mental Health Division (MHD), Children's Administration (CA) and the Juvenile Rehabilitation Administration (JRA) to review and recommend Evidence Based Practices for children and youth. The main charge of the expert panel was to create a menu of Evidence Based Practices for the three administrations to focus training and implementation activities.

The Work Group recommended, and the Assistant Secretaries endorsed, the use of a model developed in Hawaii. The premise behind the Hawaii model is to use local experts to select, review and rank practices and interventions. Using selected practices, Hawaii was able to create a menu of services that was used to guide implementation of Evidence Based Practices.

The expert panel reviewed and modified a list of clinical problems identified by youth and families receiving services from the three administrations. Then the Expert Panel conducted literature reviews of a multitude of psychosocial treatments for children and youth and adolescence and ranked them. The review was thorough, but not exhaustive, and was driven by consensus. Using the criteria developed by Hawaii, practices were ranked into 4 categories: best empirical support, good or moderate support, support as a promising practice, or as practices having known risks. The guidelines used for this ranking are listed later in this report.

It is expected that these rankings will change over time as new practices are introduced to the field, promising practices undergo more research and evaluation, and existing best practices are modified and refined. Therefore, it is the expert panel's recommendation that the menu be reviewed and revised regularly, at least once every two years.

Implementation Issues

The panel had concerns about creating a menu of practices without discussion of how, and if, the menu was to be implemented. The panel felt, in general, that it is important to consider issues of implementation and adoption while creating the menu. The expert panel highlighted the following issues as crucial components in planning for implementation and adoption of any evidence based practices with children and youth and families. The development of plans and processes to address these issues were beyond the scope of this expert panel. However, each issue is discussed in detail below and the group made recommendations where possible.

Engaging the Community

Engaging the community, both families and providers, in the development process was seen as crucial to any plan to implement EBPs. Adoption of EBPs requires a shift in the treatment culture, both from clinicians and from those receiving services. This shift has the potential to be viewed negatively without a great deal of proactive intervention. Clinicians may feel that their professional judgement and autonomy is being stripped away or questioned. Families may feel that they are being labeled, being shifted into one-size-fits-all approaches, or that they will not be able to gain access to treatments that will help them. When both clinicians and families are skeptical about adopting EBPs, any new project will fail.

However, there are interventions that can be put into place as part of an EBP implementation plan that will increase the acceptability of the project and begin to develop support for EBPs prior to adoption. Widespread education about EBPs is the first step. Education should be geared toward administrators, families, clinicians and clinical managers and should highlight the effectiveness of EBPs in treating youth and families with problems just like theirs. It should also demonstrate the individualized nature of the EBPs, and, if possible, might include a clinician or family who has successfully completed the treatment. The idea is to build local champions for the practice, and then provide support to the champion or champions to actually move the practice forward.

Assessment

Evidence Based Practices are based on research studies conducted with groups of people with similar diagnoses or problems. They are practices that have been shown to be superior to no treatment or alternative interventions for individuals with specific problems or diagnoses. A characteristic of effective interventions is that they are specifically matched to identified problems/needs. The practices lose their effectiveness, and in some cases are harmful, if they are used for persons who do not have the criterion disorder or belong to the targeted group. Clinicians must be able to accurately and reliably identify problems and make diagnoses for EBPs to have utility.

The panel recommends that a clinical assessment always be conducted prior to selecting an intervention.

Qualified Staff

The challenges of finding and retaining qualified staff are significant in the mental health field, especially in rural communities. It is even more difficult to find mental health staff who have been trained in evidence based practices. This initiative will require a major commitment to training. Not only initial training, but also ongoing training efforts to address staff turn-over, specialized training for clinicians working with minority populations, and “refresher courses” for staff who have been conducting the practices for

some time. Development of professional training in EBPs should be encouraged at both the community college and university level.

Cultural Competency

This is a critical issue throughout all mental health practices and is far beyond the scope of this expert panel. The issues related to culturally competent care are especially salient in EBPs. Some argue that EBPs have largely been studied only with white, middle-class families, and that issues of race and culture have not been factored into the development of these practices. Therefore, the argument goes, the practices are not suitable for families of different race and cultural backgrounds.

First, this argument is not true for many of the EBPs reviewed by the expert panel. Many of the practices listed by the expert panel have been studied with low income and ethnic minority groups. For a subgroup of studies, however, ethnic minorities have not been included. One recommendation would be to conduct a literature review highlighting studies where low income and ethnic minority groups were included. Implementation planning could begin with those practices that have included diverse populations and cultures in their development. There will still be some diverse populations who have not been included in any studies and the expert panel would recommend that practices be tailored to best meet the needs of these groups. Further studies could be developed to validate any modifications made to the original practices.

Furthermore, cultural considerations are very relevant to engagement and acceptability of any form of treatment including EBPs. There is substantial evidence that clients from some minority populations are less often referred for mental health services and less often follow-up with services. This speaks to the fact that mental health care is not only about the specific interventions but is also about clients' beliefs, values and confidence. These factors may be especially salient for those obtaining mental health services via the juvenile justice or child welfare system when help seeking may not be voluntary. Significant effort should be expended to identify ways to specifically address concerns and barriers for diverse communities.

Organizational and Financial Support

Administrators, clinicians and supervisors must support the training and on-going supervision required for evidence based practices. This support may be in the form of release time, staff payment and agency wide promotion of the overall program philosophy. On-going supervision requirements alone require a substantial change of practice for many organizations.

It is important to take into account that there are costs associated with start up and ongoing monitoring and supervision requirements. A budget for training, including travel, staff supervision, transportation and staff payment is critical to the success of the program. Staff productivity measures may decline early in the implementation phase, so providers should account for this in budget projections. Savings may not be evident for

several years and the agencies providing the services may not be the direct beneficiary of the savings. Financing strategies will need to take these factors into account.

Fidelity is an important consideration in the adoption of EBPs. EBPs are standardized treatment protocols that have demonstrated improved outcomes in those clients who receive the treatment. Assessing the fidelity of the actual service delivered to the standards put forth in the model is a crucial activity in ensuring that EBPs are taking place. This will take time and resources and policies to determine at how and at what level of the system fidelity assessments will occur. This is an important topic for implementation planning

Inter and Intra-organizational change

Implementation and adoption may require crossing organizational boundaries and impacting the social ecology of the agencies and populations served. Organizational change is hard, and will require careful planning, coordination and open communication.

The expert panel offers its expertise for further planning and development related to any of the topic areas listed above.

Evidence Based Practices Menu

The guidelines and menu are listed below. The menu establishes that for all target problems and target populations there are interventions that have either the highest level of support or some evidence for effectiveness. The Expert Panel believes that the Juvenile Rehabilitation Administration, the Mental Health Division and the Children's Administration should favor empirically tested and proven interventions when purchasing services. They support these interventions because they are effective, have manuals that clearly specify the procedures to be used and can easily be learned. However, they are not recommending that the state only support "manualized", off the shelf protocols. Interventions that have not yet been fully tested, but are based on established principles of behavior change and explicitly describe the procedures in some form of a manual may also be acceptable. They recommend that the child serving divisions of DSHS undertake a coordinated and assertive effort to increase the availability of empirically supported interventions in our state.

The Expert Panel discussed the service delivery process known as "Wraparound " at some length. The panel determined that Wrap-around is a service delivery process through which any of the listed EBPs could be administered as part of a coordinated, individualized care plan. The principles and values of Wraparound, such as services are family driven and care is individualized to the unique needs of each child and family, should be incorporated into implementation planning efforts.

The Expert Panel believes that there are circumstances where strict application of the evidence based practice protocol is the preferred approach. When the potential

consequences of intervention failure are severe or accrue to innocent victims a greater priority should be placed on delivering interventions with the highest level of empirical support. For example, in most cases when the goal is to protect the community by decreasing recidivism, the proven interventions should be delivered as specified. There is ample evidence that departure from a specified protocol reduces the benefit of the interventions, which means more victimization. This same principle may apply to circumstances of child physical abuse where a child may be harmed if the intervention fails and there is an intervention specifically shown to reduce the risk of re-referral. Similarly, for the highest risk children and youth in foster care who have a history of placement disruption, the evidence based intervention demonstrated to be most effective should be initiated.

At the same time the Expert Panel does not wish to stifle innovation that may improve the array of services. There are interventions proven to work for one target problem area that appear very promising for application to other similar problems or populations. Multi-modal or combination approaches may be the best course for very complex case situations. However, given that there is a highly developed knowledge base on interventions for child psychopathology, novel applications or unproven interventions should reflect established principles and evidence.

Increasing the availability of evidence-based practices will require DSHS to take leadership, create incentives, and provide a supportive infrastructure. It has been consistently demonstrated that providers must have the proper training and ongoing supervision if the interventions are to be carried out faithfully and be effective with children and youth and families. Furthermore, research has shown that fidelity to a proven treatment model provides the greatest outcomes to children and youth and their families. The panel believes that the DSHS can and should insure that the proper training and supervision is available and that services are appropriately reimbursed. In exchange providers can be expected to deliver evidence-based practices with fidelity and accountability.

The expert panel notes that other states, when implementing evidence based practices, did not simply create a menu based on a grid. They developed a strategy and approach to mental health services that promoted the use of the common components of evidence-based interventions. This model permits therapists to flexibly apply the components based on presenting or continuing problems of children and youth. There are accountability and feedback mechanisms built in to the structure to enable therapists to assess whether children and youth are improving and to change the treatment when they are not.

The Expert Panel believes the creation of the menu is an important first step in a process. However, in order for the program menu to be meaningful it must be accompanied by a stated policy that evidence based practices are the clear preference in certain circumstances and a commitment to take actions that will increase the availability of the interventions. This would include the intent to develop a plan toward achieving the goal.

Guidelines for Ranking Mental Health Practices

The following guidelines were used in assigning practices to different levels.

Level 1: Best Support

I. At least two good between group design experiments demonstrating efficacy in one or more of the following ways:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power

OR

II. A large series of single case design experiments (n>9) demonstrating efficacy. These experiments must have:
   a. Used good experimental designs
   b. Compared the intervention to another treatment as in I. a.

AND

Further criteria for both I and II:

III. Experiments must be conducted with treatment manuals.
IV. Characteristics of the client samples must be clearly specified.
V. Effects must have been demonstrated by at least two different investigators or teams of investigators.

Level 2: Good Support or Moderate Support

I. Two experiments showing the treatment is (statistically significantly) superior to a waiting-list control group. *Manuals, specification of sample, and independent investigators are not required.*

OR

II. One between group design experiment with clear specification of group, use of manuals, and demonstrating efficacy by either:
   a. Superior to pill placebo, psychological placebo, or another treatment.
   b. Equivalent to an already established treatment in experiments with adequate statistical power

OR

III. A small series of single case design experiments (n>3) with clear specification of group, use of manuals, good experimental designs, and compared the intervention to pill or psychological placebo or to another treatment.

Level 3: Promising Practice

i. The treatment has a sound theoretical basis in generally accepted psychological principles, or has been demonstrated to be effective with another target behavior.
ii. A substantial clinical-anecdotal literature exists indicating the treatment's value with the target behavior.
iii. The treatment is generally accepted in clinical practice as appropriate for use with the target behavior.
iv. There is no clinical or empirical evidence or theoretical basis indicating that the treatment constitutes a substantial risk of harm to those receiving it, compared to its likely benefits.

v. The treatment has a book, manual, or other available writings that specifies the components of the treatment protocol and describes how to administer it.

Level 4: Practices with Known Risks

i. At least one study or review demonstrating harmful effects of a treatment.

Evidence-Based Child and Adolescent Psychosocial Interventions

Problem Area	Level 1 – BEST SUPPORT	Level 2 – GOOD SUPPORT OR MODERATE SUPPORT	Level 3 – PROMISING PRACTICES	Level 4– KNOWN RISKS
Anxious or Avoidant Behaviors	Manualized Cognitive Behavior Therapy for Anxiety Disorders			
Attention and Hyperactive Disorders	Multi-Modal Approaches using Medication +Cognitive Behavioral Therapy + Parent Training + School Intervention			
Autistic Spectrum Disorders	Applied Behavior Analysis		Auditory Integration Training; Functional Communication Training	
Bipolar Disorders	Medication;		Multi-Family Group Treatment:**; Family Psychoeducation**, CFF-Cognitive Behavioral Therapy; Cognitive Behavioral Therapy-IP	
Depressive or Withdrawn Behaviors	Manualized CBT for Depression; Interpersonal Therapy (Manualized IPT-A); Medication		Dialectical Behavior Therapy	
Eating Disorders		Family Therapy (anorexia only)	Dialectical Behavior Therapy; Cognitive Behavioral Therapy; Interpersonal Therapy	Some Group Therapies
Disruptive and Oppositional Behaviors	Parent & Teacher Behavior Management (e.g. Incredible Years, Barkley curriculum, Patterson curriculum); Parent- Child Interaction Therapy	Anger Coping Therapy; Functional Family Therapy*	Multi-Systemic Treatment*; Cognitive Behavioral Therapy, Dialectic Behavioral Therapy; Multi-Dimensional Treatment Foster Care*	Group therapy without a skills focus
Self-harming Behaviors			Dialectic Behavior Therapy; Multi-Systemic Treatment	
Assaultive/aggressive Behaviors	Aggression Replacement Therapy	Multi-Systemic Treatment*	Multi-Dimensional Treatment Foster Care*	

Sexually aggressive Behaviors		Multi-Systemic Treatment; Cognitive Behavioral Therapy for Children with Sexual Behavior Problems		
Traumatic stress	Trauma-focused Cognitive Behavioral Therapy	Eye Movement Desensitization & Reprocessing; Cognitive Behavioral Therapy for Children with Sexual Behavior Problems	Trauma-Focused Integrative Eclectic Therapy; Trauma-Focused Play Therapy	
Interpersonal Relationships	Cognitive Behavioral Therapy; skills training		Dialectic Behavior Therapy; Functional Family Therapy	
Attachment Problems (0-5)		Parent-Child Interaction Therapy; Behavioral Parent Training; Family Focused, Child Centered Treatment		Coercive or Aversive therapies; Attachment Therapy
Schizophrenia and other psychotic disorders	Medication	Assertive Community Treatment for Adolescence; social skills training	**Family Psychoeducation; **Multi-Family Group Treatment	
Substance Use		Voucher-Based Contingency Management; Purdue Brief Family Therapy; Motivational Enhancement Therapy; Multi-Dimensional Treatment Foster Care***; Multi-Systemic Treatment***	Dialectic Behavior Therapy CBT**	Group Therapy
High Conflict Families		Functional Family Therapy*	Cognitive Behavioral Therapy: Intensive Family Preservation Services; Parenting Wisely	

* These practices show Level 1-Best Support for Juvenile Offenders
** Based on findings with adults only;
*** These interventions are effective if substance abuse is part of a more complex diagnostic picture

Population based Interventions

Population	Level 1 – BEST SUPPORT	Level 2 – GOOD SUPPORT OR MODERATE SUPPORT	Level 3 – PROMISING PRACTICES	Level 4– KNOWN RISKS
Juvenile Offenders	Multisystemic Therapy, Multi-Dimensional Treatment Foster Care; Functional Family Therapy; Aggression Replacement Therapy	Dialectic Behavior Therapy, Family Integrated Therapy (FIT)		Group therapy without a skills focus
At Risk for Out of Home or More Restrictive Placement	Multi-Dimensional Treatment Foster Care.	Parent-Child Interaction Therapy; Behavioral Parent Training; Family Focused, Child Centered Treatment (FTI)	Intensive Family Preservation Services	
Families at risk for child physical abuse		Abuse Focused Cognitive Behavioral Therapy. Parent-Child Interaction Therapy		
School-Aged Prevention Programs		Promoting Alternative Thinking Strategies (PATH); Project ACHIEVE; Families And Schools Together (FAST); Anger Coping-Self-Instruction Training		

Expert Panel Recommended Next Steps

The Expert Panel would like to provide technical assistance to the three DSHS administrations as they develop their implementation, and education and training plans. The experts on the panel all have experience implementing and sustaining novel and evidence based practices into community settings. There will be global overarching implementation issues, but there will also be implementation issues unique to individual providers. DSHS will need to be able to address the issues at both levels for this project to be successful.

Financing and structure are important considerations when moving a project forward and the panel feels confident that the three DSHS administrations will plan appropriately for those issues. However, there are many clinical, educational, motivational, and sustainability issues that also need to be addressed. The expert panels input would be invaluable for planning on those issues.

Fitting this body of work into a menu required the Expert Panel to make some assumptions and interpretation. The panel recommends that before these practices are implemented in the community further planning and refinement is necessary. A further caveat is that the panel did not review practices related to infancy.

In closing, we would like to thank the three assistant secretaries for the opportunity to provide input into this process. We would further warn the three assistant secretaries of the enormity of the tasks ahead. This project will require DSHS to take leadership, create incentives, and provide a supportive infrastructure. We would be willing to serve as technical consultants to the child serving divisions of DSHS as they undertake a coordinated and assertive effort to increase the availability of empirically supported interventions in our state.

Problem List

Problem Area	Practice	Expert	Articles
Anxious or Avoidant Behaviors	Manualized Cognitive Behavior Therapy (CBT) for Anxiety Disorders	• Ollendick, T.H. & King, N.J.	Empirically supported treatments for children w/phobic & anxiety disorder. Journal of Clinical Child Psychology, 27, 156-167 (1998).
		• Bandura, A.	Psychological Modeling: Conflicting Theories. Chicago, IL: Aldine-Atherton. (1971).
		• Kendall, P.C.	Treating Anxiety Disorders in Children; Journal of Consulting and Clinical Psychology, 62, 100-110(1994).
		• Barrett, P.M. et al.	Family treatment of childhood anxiety: A controlled trial; J of C&CP, 64, 333-342 (1996).
		• Barlow, D.	CBT for panic disorder; Journal of Clinical Psychiatry, 58(Suppl.2)32-37 (1997).
		• Barnett, P.M.	Evaluation of cognitive-behavioral group treatment for childhood anxiety disorders. Journal of Clinical Child Psychology, 27, 459-468. (1998).
Attention and Hyperactive Disorders	Multi-Modal Approaches using Medication + Cognitive Behavioral Therapy + Parent Training	• Barkley, R.A.	Defiant Children: A Clinician's Manual for Assessment & Parent Training, NY: Guilford Press (1997).

	+ School Intervention CBT with parent, child and school involvement	• Webster-Stratton, C.	Randomized trial of two parent-training programs for families with conduct-disordered children. Journal of Consulting and Clinical Psychology, 52, 666-678 (1984).
Autistic Spectrum Disorders	Applied Behavior Analysis Auditory Integration Training; Functional Communication Training	• Rogers, S.J., et al. • Rimland, B. & Edelson, S.M. • Durand, et al.	A comparative study. Topics in Early Childhood Special Ed.11, 29-47 (1991). Brief Report: A pilot study of auditory integration training in autism. Journal of Autism & Development Disorders, 25, 61-70. (1995). Functional Communication Training to reduce challenging behavior. Journal of Applied Behavioral Analysis 24, 251-264 (1991).
Bipolar Disorders	Medication; *Multi-Family Group Treatment; CFF-Cognitive Behavioral Therapy; Cognitive Behavioral Therapy; Interpersonal Therapy;	• Dixon, L., McFarlane, WR, Lefley, H. et al. • Pateli-Siotis, I., Young, L. T., et al. • Mufson et al.	Evidence-based practices for services for families of people with psychiatric disabilities, Psychiatric Services 52:903-910, 2001. Group CBT for bipolar disorder. Journal of Affective Disorders, 65, 145-153. (2001). Efficacy of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, 56, 573-579

			(1999)
Depressive or Withdrawn Behaviors	Medication Manualized CBT for Depression; Interpersonal Therapy (Manualized IPT-A); Dialectical Behavioral Therapy*	• Compton, Scott et al. • Mufson et al. • Miller, A. L., Wyman, S.E., Huppert, J.D., Glassman, S.L. & Rathus, J.H. • Rathus, J.H. & Miller, A.L.	Cognitive-Behavioral Psychotherapy for Anxiety and Depressive Disorders in Children & Adolescents: An E-B Medicine Review, J. Am. Acad. Child &Adolescent Psychiatry, 43:8, Aug. 2004. Efficacy of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, 56, 573-579 (1999). Analysis of behavioral skills utilized by suicidal adolescents receiving DBT. Cognitive & Behavioral Practice, 7, 183-187. (2000). Dialectical Behavior Therapy Adapted for Suicidal Adolescents. Suicide and Life-Threatening Behavior, 32, 146-157.
Eating Disorders	Family therapy (anorexia only); Dialectical Behavioral Therapy	• Eisler, I. et al. • Telch, C.F., Agras, W.S., & Linehan, M.M.	Family therapy for adolescent anorexia nervosa. Journal of Child Psychology & Psychiatry, 41(6), 727-736 (2000) Group dialectical behavior therapy for binge-eating disorder: A preliminary, uncontrolled trial. Behavior Therapy, 31. 569-582. (2000). Dialectical behavior therapy for binge eating disorder. Journal of Consulting and Clinical Psychology, 69, 1061-1065. (2001).

	CBT & IPT (bulimia only) Interpersonal Therapy (Manualized IPT-A);	• Telch, C.F., Agras, W.S.& Linehan, M.M. • Mufson et al.	A multi-center comparison of CBT & IP for bulimia nervosa. Archives of General Psychiatry, 57, 459-466 (2000). Efficacy of interpersonal psychotherapy for depressed adolescents. Archives of General Psychiatry, 56, 573-579 (1999).
Disruptive and Oppositional Behaviors	Parent &Teacher Training (e.g. Incredible Years; parent/teacher behavior management Barkley curriculum; Patterson curriculum) Parent Child Interaction Therapy; Anger Coping Therapy Functional Family Therapy Multi-Systemic Treatment Multi-Dimensional Family Treatment	• Webster-Stratton, C. • Chaffin, Mark et al. • Lochman, et al. • Alexander, J. et al. • Henggeler, S.W. et al. • Liddle, H. A	Randomized trial of two parent-training programs for families with conduct-disordered children. Journal of Consulting and Clinical Psychology, 52, 666-678 (1984). P-CIT w/Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports. Journal of Consulting & Clinical Psychology 3004, vol. 72, No.3, 500-510 (2004). Cognitive-behavioral intervention w/ aggressive boys. Journal of Consulting & Clinical Psychology, 10, 426-432 (1992). Blueprints for Violence Prevention, Book Three: Functional Family therapy, Boulder, CO: Center for the Study and Prevention of Violence. (1998) MST of juvenile offenders, etc. Developmental Psychology, 22, 132-141 (1986). Center for Treatment Research on Adolescent Drug Abuse, Dept. of Psychiatry & Behavioral medicine, Univ. Of Miami School of Me., Miami, FL.

	DBT* CBT	• Trupin, Eric, et al. • Kazdin, A.E., Bass, D., Siegel T. & Thomas, C.	DBT Program for Incarcerated Female Juvenile Offenders, Child & Adolescent mental health, Vo. 7, No. 3, 121-127 (2002). Cognitive-behavioral & relationship therapy in the tx of children referred for antisocial behavior. Journal of Consulting & Clinical Psychology, 55, 522-535. (1989)
Self-harming Behaviors	DBT* MST	• Linehan, M.M., Tutek, D.A., Heard, H. L. & Armstrong, H. E. • Heneggler, S.W., et al.	Interpersonal outcome of cognitive behavioral tx for chronically suicidal borderline patients. American Journal of Psychiatry, 151, 1771-1776. (1994). MST of juvenile offenders, etc. Developmental Psychology, 22, 132-141 (1986).
Assaultive/ Aggressive Behaviors	Aggression Replacement Therapy; Multi-Systemic Therapy Multi-Dimensional Family Treatment	• Goldstein, Arnold P, et al. • Heneggler, S.W., et al. • Liddle, H. A.	Aggression Replacement Training, A Comprehensive Intervention for Aggressive Youth. Research Press, IL. (July 1998.) MST of juvenile offenders, etc. Developmental Psychology, 22, 132-141 (1986). Center for Treatment Research on Adolescent Drug Abuse, Dept. of Psychiatry & Behavioral Medicine, Univ. of Miami School of Medicine, Miami, FL.
Sexually aggressive Behaviors	MST CBT for children w/ Sexual Behavior Problems	• Borduin, C.M. & Schaeffer, C. M. • Saunders, B.E.,	MST of Juvenile Sexual Offenders: A Progress Report., pp. 25-42. The Haworth Press, 2001. Child Physical & Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National

		Berliner, L. & Hanson, R.F. (Eds.)	Crime Victims Research &Treatment Center, p.34-36 (2004).
Traumatic stress	Trauma focused CBT;	• Cohen, J.A., & Mannarino, A.P. • Cohen, J.A. & Mannarino, A.P., & Steer, R.A. • Deblinger, E. Lippman, J. & Steer, R.A. • Deblinger, E., Steer, R.A. & Lippman. • King, N.J., Tonge, B.J., Mullen, P. et al. • Mannarino, A.P., & Cohen, J.A.	A treatment outcome study for sexually abused preschool children: Initial findings. Journal of the Amer. Acad. Of Child & Adol. Psychiatry, 35, 42—50. (1996). Interventions for sexually abused children: Initial treatment findings. Child Maltreatment,3,17-26 (1998). A multisite randomized controlled trail for children w/sexual abuse-related PTSD symptoms. Journal of the Amer. Acad. Of Child & Adol. Psychiatry. 43, 393-402. (2004). Sexually abused children suffering posttraumatic stress symptoms: Initial treatment outcome findings. Child Maltreatment, 3, 310-321. (1996). Two-year follow-up study of cognitive-behavioral therapy for sexually abused children suggering posttraumatic stress symptoms. Child Abuse & Neglect, 23, 1371-1378. (1999) Treating sexually abused children with PTS symptoms: A randomized clinical trail. Journal of the Amer. Acad. Of Child & Adol. Psychiatry, 39, 1347-1355. (2000). A follow-up study of factors that mediate the development of psychological symptomatology in sexually abused girls. Child Maltreatment, 1, 246-260. (1996).

	EMDR;	• Stein, B.D., Jaycox, L.H., et al. • Chemtob, C.M., et al.	A mental health intervention for school children exposed to violence: A randomized controlled trail. Journal of the Amer. Med. Assoc., 290, 603-611. (2003). Brief Treatment for Elementary School Children w/Disaster-related PTSD: A field study. Journal of Clinical Psychology, 58(1), 99-112.(2002).
Interpersonal Relationships	CBT; Skills Training FFT DBT*	• LeSure-Lester, G.E. • Alexander, J. et al. • Linehan, M.M. et al.	An Application of Cognitive-Behavioral Principles in the Reduction of Aggression Among Abused Afr. Amer. Adol., Journal of Interpersonal Violence, 17(4), 394-402.(2002). Blueprints for Violence Prevention, Book Three: Functional Family Therapy, Boulder, CO: Center for the Study and Prevention of Violence. (1998) Interpersonal Outcome of Cognitive Behavioral Treatment for Chronically Suicidal Borderline Patients. Am. Journal of Psychiatry, 151, 1771-1776. (1994)
Attachment Problems (0-5)	Parent-Child Interaction Therapy; Behavioral Parent Training;	• Chaffin, Mark et al. • Saunders, B.D., Berliner, L. & Hanson, R.F. (Eds.)	P-CIT w/ Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports, Journal of Consulting & Clinical Psychology, 3004, vol. 72, No. 3, 500-510 (2004). Child Physical and Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research and Treatment Center, pages 61-65. (2004). Saunders, B.F., Berliner, L., et al. (Eds.). Child Physical and

		•	Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research and Treatment Center, pages 66-68. (2004).
Schizophrenia and other psychotic disorders	Medication; Assertive Community Treatment for Adolescence; Social Skills Training *Psychoeducational Therapy for the Patient and the Family; *****Multi-Family Group Treatment	• NAMI (web.nami.org/about/pact. htm) • Spencer, P.G., Gillespie, C.R. & Ekisa, E.G. • APA, 1997; • Rund et al., 1994 • APA, 1997	Drake, R.E., Mueser, K.T., Torrey, W.C., et al. Evidence-based tx of schizophrenia. Current Psychiatry Reports, 2, 393-397. (2000). A controlled comparison of the effects of social skills training and remedial drama on the conversational skills of chronic schizophrenic inpatients. British Journal of Psychiatry, 143, 165-239-247. (1983). Practice guideline for the tx of patients w/schizophrenia. APA, 154(Suppl. 4), 1-64 (1997). The Psychosis Project outcome and cost-effectiveness of a psychoeducational treatment programme for schizophrenic adolescents, Acta Psychiatrica Scandinavia, 89, 211-218. (1994). Practice guideline for the tx of patients w/schizophrenia. APA, 154(Suppl. 4), 1-64 (1997).
Substance Use	CBT; Purdue Brief Family Therapy;	• Bolvin, et al. • Trepper, Terry	Long-term follow-up results of a randomized drug abuse prevention trial in a white middle class pop. JAMA, 273, 1106-1112 (1995). McCollum, E.E. & Trepper. T.S. Family solutions for drug & alcohol abuse: Clinical & counseling approaches. N.Y.: The

	MST; Motivational Enhancement Therapy; Voucher-Based Contingency Management; MDFT (Multidimensional Family Therapy) DBT*	• Randall, J. at al. • Miller, William R. • Higgins, S. et al • Liddle, H. A. • Linehan, M.M., Schmidt, H. et al	Haworth Press. 2001. MST: A tx for violent, substance-abusing&substance dependent juvenile offenders. Addictive Behaviors 23, 1731-1739 (2003). MET meets the real work, etc. Journal of Substance Abuse Tx 23, 73-80 (2002). Dept. of Psych. (CASAA), Univ. of NM, Albuquerque, NM; http://motivaltionalinterview.org/clinical/METDrugAbuse.PDF(10/26/95) Achieving cocaine abstinence w/a behavioral approach. American Journal of Psychiatry. 150(5), 763-769 (1993). Center for Treatment Research on Adolescent Drug Abuse, Dept. of Psychiatry & Behavioral medicine, Univ. Of Miami School of Me., Miami, FL. DBT for patients w. BPD & drug dependence. Amer. Journal on Addiction, 8, 279-292. (1999).
High Conflict Families	Functional Family Therapy CBT with parent, child and school involvement Intensive Family	• Alexander, J. et al. • Webster-Stratton, C. • Booth, C.L.	Blueprints for Violence Prevention, Book Three: Functional Family Therapy, Boulder, CO: Center for the Study and Prevention of Violence. (1998) Randomized trial of 2 parent-train'g programs for families w/conduct-disordered children, Journal of Consulting and Clinical Psychology, 52, 666-678 (1984).

	Preservation Services Parenting Wisely	• Gordon, Donald	Fraser, Walton, Lewis, et al. An Experiment in family reunification: Correlates of outcomes at one-year follow-up. Services Review, 16, 335-361(1996). Family Works, Inc., 340 State St., Room 135B, Unit 19, Athens, Ohio 45701-3751; www.parentingwisely.com (SAMHSA NREP Model Program)
Population List			
Juvenile Offenders	Multisystemic Therapy; Multidimensional Treatment Foster Care; Functional Family Therapy; Aggression Replacement Therapy; Dialectical Behavioral Therapy	• Heneggler, S.W., et al. • Chamberlain, P. & Mihalic, S. F. • Alexander, J. et al. • Goldstein, Arnold P, et al. • Eric Trupin et al.	MST of juvenile offenders, etc. Developmental Psychology, 22, 132-141 (1986). Blueprints for Violence Prevention, Book Eight: Multidimensional Treatment Foster Care. Boulder, CO: Center for the Study & Prevention of Violence. (1998). Blueprints for Violence Prevention, Book Three: Functional Family therapy, Boulder, CO: Center for the Study and Prevention of Violence. (1998) Aggression Replacement Training, A Comprehensive Intervention for Aggressive Youth. Research Press, IL., July 1998. DBT Program for Incarcerated Female Juvenile Offenders, Child & Adolescent mental health, Vo. 7, No. 3, 121-127

			(2002). Cognitive-behavioral & relationship therapy in the tx of children referred for antisocial behavior. Journal of Consulting & Clinical Psychology, 55, 522-535. (1989)
At Risk for Out of Home Placement	Parent-Child Interaction Therapy; Behavioral Parent Training; Family Focused, Child Centered Treatment	• Chaffin, Mark et al. • Saunders, B.E., Berliner, L. & Hanson, R.F. (Eds.) • Saunders, B.E., Berliner, L. & Hanson, R.F. (Eds.)	P-CIT w/Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports. Journal of Consulting & Clinical Psychology 3004, vol. 72, No.3, 500-510 (2004) Child Physical & Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research &Treatment Center, p. 61-65 (2004). Child Physical & Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research &Treatment Center, p. 66-68 (2004).
History of Abuse & Neglect	Parent-Child Interaction Therapy; CBT & Dynamic Play Therapy for Children w/ Sexual Behavior Problems & Their Caregivers; Family Focused, Child Centered Treatment in	• Chaffin, Mark et al. • Saunders, B.E., Berliner, L. & Hanson, R.F. (Eds.) • Saunders, B.E.,	P-CIT w/Physically Abusive Parents: Efficacy for Reducing Future Abuse Reports. Journal of Consulting & Clinical Psychology 3004, vol. 72, No.3, 500-510 (2004). Child Physical & Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research &Treatment Center, p.34-36 (2004). Child Physical & Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research &Treatment Center, p.66-67 (2004).

	Child Maltreatment (FTI) Eye Movement Desensitization & Reprocessing (EMDR); Child/Parent Physical Abuse CBT; Trauma-Focused Integrative Eclectic Therapy; Trauma-Focused Play Therapy	Berliner, L. & Hanson, R.F. (Eds.) • Saunders, B.E., Berliner, L. & Hanson, R.F. (Eds.) • Saunders, B.E., Berliner, L. & Hanson, R.F. (Eds.) • Saunders, B.E., Berliner, L. & Hanson, R.F. (Eds.) • Saunders, B.E., Berliner, L. & Hanson, R.F. (Eds.)	Child Physical & Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research &Treatment Center, p.39-42 (2004). Child Physical & Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research &Treatment Center, p.43-44 (2004). Child Physical & Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research &Treatment Center, p. 52-53 (2004). Child Physical & Sexual Abuse: Guidelines for Treatment (Revised Report: April 26, 2004). Charleston, SC: National Crime Victims Research &Treatment Center, p.54-55 (2004).
School-Aged Prevention	Promoting Alternative Thinking Strategies (PATH); Project ACHIEVE	• Kusche, Carol A. • Knoff, Howard M.	Prevention Research Center, Penn. State Univ. Univ. Park, PA; www.prevention.psu.edu/PATHS/ (SAMHSA NREP) Institute for School Reform, Integrated Services & Child Mental Health & Ed. Policy, Little Rock, AR; www.projectachieve.info

	Families And Schools Together (FAST)	• McDonald, Lynn	(SAMHSA NREP) Wisconsin Center for Education Research, Univ. of Wisconsin-Madison; www.wcer.wisc.edu/fast (SAMHSA NREP)
	Anger Coping -Self-Instruction Training	• Lochman, John E.	Cognitive-Behavioral Intervention with Aggressive Boys, 3 yr. Follow-up and Preventive Efforts. Journal of Consulting and Clinical Psychology 60:426-32. (1992). (NIJ: What Works).

Evidence Based Treatment Website references

University of South Florida/Louis de la Parte Florida Mental Health Institute
http://nirn.fmhi.usf.edu/

link on EBPs and cultural competency:
http://nirn.fmhi.usf.edu/resources/publications/working_paper_3b.pdf

Blueprints link:
http://www.colorado.edu/cspv/blueprints/model/overview.html

State of Virginia's Evidence Based Practices

http://coy.state.va.us/Modalities/contents.htm

Washington State Institute for Public Policy. July 2004 study on "Benefits and Costs of Prevention and Early Intervention Programs for Youth"

www.wsipp.wa.gov

DSHS Mental Health Disvisions Best Practices

http://www1.dshs.wa.gov/Mentalhealth/bestpracticesguide.shtml

Virginia Commission on Youth - Modalities Contents, the reference chart of disorders and EBPs.http://coy.state.va.us/Modalities/refchart.htm

Hawaii's mental http://www.hawaii.gov/health/mental-health/camhd/resources/index.html

Appendix 4: Interview Questions

INTERVIEW QUESTIONS

PROGRAM NAME: _____

INTERVIEWEE: _____ INTERVIEWER: _____

DATE: _____

I. *Practice*: Family and community engagement, together with school efforts, promotes a school climate that is safe, supportive and respectful. It provides an array of mental health services and educational opportunities to meet the mental health and academic needs of the student and his/her family.

Evidence: Information Dissemination

1. What informational materials are provided to families and community members about mental health services and educational opportunities?

2. Are families invited to public meetings? How?

3. Are family members encouraged to ask questions and provide input about the mental health and academic needs of their children and the families? How?

4. Are mental health and education providers' staffs culturally/linguistically competent? In what way?

5. Who are your community partners?

II. *Practice*: The school and mental health providers coordinate training for school staff, communities, and families.

Evidence: Training

1. How are individuals in the community notified of trainings?

2. How are community and family members who are linguistically diverse and/or from different cultures included in training opportunities?

3. How accessible are the trainings?

4. How often are trainings provided?

5. How are trainers identified?

6. What experiences or credentials do trainers have?

III. *Practice*: Mental health providers and school staff work together to provide an integrated and comprehensive array of mental health services and education opportunities.

Evidence: Integrated Services

1. What practices are in place to ensure an integrated and comprehensive array of mental health services within educational settings?

2. How often is your interagency agreement or MOU reviewed/revised?

3. Describe the funding for this program?

4. What mechanisms are in place for sustainability?

IV. *Practice*: The mental health providers and schools coordinate data collection and analysis.

Evidence: Data

1. Is there an interagency agreement/MOU in place? What are the components?

EXAMPLES OF ACTIVITIES THAT PROMOTE PROMISING PRACTICES

House Bill 1784 – 2003 Washington State Legislative Session

I. Practice: Family and community engagement, together with school efforts, promotes a school climate that is safe, supportive and respectful. It provides an array of mental health services and educational opportunities to meet the mental health and academic needs of the student and his/her family						
Evidence: (Information Dissemination)	**Informational Materials/Documents**	**Public Meetings**	**Environment/Culture**	**Culturally/Linguistically Competent Staff**	**List of Community Partners**	**Interagency Agreement/ Memorandum of Understanding (MOU)**
Indicator 1: ***Evidence of outreach to families with mental health needs***	Parent Handbook includes • Program description • Program expectations • Team process training Program flyers sent to all district families via mail, e-mail, student delivery, and posted in obvious public view places Telephone calls/phone tree, E-mail listserv Newsletter distribution Special attention paid to	Community wide training Public notifications of meetings are made/invitations are sent out. Meeting minutes provided through various sources including newsletters and direct mailing/ e-mailing Parenting classes	Treatment occurs in centers that are culturally centered The culture of the student and family is recognized, respected and upheld Wraparound planning is used that incorporates a wide array of community members	Multi-lingual brochures Staff culture and family culture match Bilingual/bicultural staff are available for consultation Minority mental health specialists are used to address issues culturally appropriately Interpreters available Utilize university- based multicultural program	Public schools including Special Education and Educational Services Districts and Community Mental Health Agencies, Crisis Response Teams Child Welfare, Juvenile Justice, Developmental Disabilities, local public health, chemical dependency treatment programs, outdoor recreation programs, service clubs, parents/family members and caregivers on student's team as well as other	Agreements signed by key agency individuals/decision makers Cross system referral process addressed in agreements Agreements are "working" documents Revisit agreements at a minimum every 2 years

	isolated families/students (e.g., homelessness, extreme poverty, etc.)	with meals that are provided by service clubs		resources for consultation	agencies that enhance the overall health of families and the community	
Indicator 2: ***Connection to appropriate and local resources and advocacy for families***	Informational videos for parents to check out Therapist meets parents at school after referral Family members are part of sessions for student treatment	Informational meetings are held with local agency representation to discuss program access	Early intervention/doesn't require an open CPS case to get services	Parents choose providers and team members	Use family focus groups to define education/mental health needs of students to strategize who the players should be	Agreements should reflect family centered approach
Indicator 3: ***Individual voices are encouraged and valued as equal partners in program development and improvement***	Parents are trained and used as mentors for other parents who experience systemic struggles	Parents are used as experiential trainers at public meetings	Mental health services provided in the home as much as possible	Parents are encouraged to drive the treatment process	Community connections defined by community members	Agreement addresses how the voice of the student and family will be recognized throughout the community
Indicator 4: ***Services are provided in a safe and healthy environment***	Local health clinics, Primary Care Providers offices; School-based health clinics Space provided by district for MH therapists to allow for individual and group work with students	District provides space for community gatherings	Parents make decisions as to where team meetings are held Services provided in school environment and include teachers	Services provided in the language and culture of the student/family	Use a variety of community member engagement and holding meetings at partner agencies, when appropriate as a show of community support for mental health needs	Wraparound model; therapeutic respite program through licensed foster homes

II. <u>Practice</u>: The school and mental health providers coordinate training for school staff, communities, and families						
Evidence: (Training)	**Public Announcements**	**Knowledgeable Trainers (credentials/ experience)**	**Environment/ Culture**	**Culturally/ Linguistically Competent Staff**	**Training Materials**	**Alternative Training Materials and Format**
Indicator 1: ***Training opportunities are evident***	Announcements are mailed out to all families who have children enrolled in the district Other partnering agencies host and sponsor events and help with publicity	IEP Training by Special Education. Directors; MH and DD training by project managers District staff is trained to identify mental health needs and access routes to services	Written policies regarding access to mental health services reflects appropriate language and cultural norms for the community	Training is provided in various languages for all community members Parents are co-trainers and partners in training process	Include a variety of community entities and publications, including criminal justice system, in preparing curriculum and training	Experiential training opportunities provided when possible
Indicator 2: ***Training provided is accessible to all individuals***	Fliers are posted in prominent locations throughout the community	Trainers have common experiences with those they train Guest speakers (national and local experts) are invited to community wide information sharing Tap into community expertise	Training occurs where one can reach the most people at any one time All meetings and trainings are held in ADA approved facilities	Training available at public mental health agency and at local school buildings on the identification and treatment options for students with mental disorders Translators are provided for ELL families	Reflects the various languages of the community served by the mental health agencies	Translators available Materials in languages appropriate for all community members Training provided whenever deemed necessary

Indicator 3: ***Trainers have proper knowledge base***	Resumes/vitas of trainers presented as part of publications	Mentors are available for coaching and guidance, e.g., parent to parent, student to student programs	Training based on "needs" data gathered through formalized assessment of community needs	Mentors reflect the culture and ethnic backgrounds of individuals they mentor	Use researched-based curriculum that can be "tweaked" to meet local needs	Seek new and innovative staff and materials through consultation with other mental health agencies and districts
Indicator 4: ***Ongoing training to provide continued learning***	Trainings published as far in advance as possible to provide adequate notification for individuals to attend	Appropriate trainers recruited to meet the assessed needs of the community	Trainings are available throughout the calendar year	Ongoing quest for new and innovative teachings by cultural minority individuals	Develop materials for the year that can be added to as needed to meet the needs of the community with regard to mental health	Continue to be open to new learning in the field of mental health and how it affects a students ability to learn

III. <u>Practice</u>: Mental health providers and school staff work together to provide an integrated and comprehensive array of mental health services and educational opportunities					
Evidence: (Integrated Services)	**Stated Student Outcomes**	**School Schedule (time and place)**	**Community/School Teams**	**Planning/ Implementing Meeting Notes**	**Interagency Agreement/MOU/Funding Streams**
Indicator 1: **School wide programs**	Stabilize student within school environment. Training on mental health issues as related to students is available for ALL school staff (including janitorial and transportation staff)	School sponsors mental health seminars as part of school wide programs Mental health awareness week is used as a launching point for training and appropriate activities	Interagency staffing team for most complex students **Teachers and administrators trained on how mental health can affect student performance – signs to watch for when a student is struggling or is at risk**	Mental health interventionist works closely with teachers and other school personnel	Blended funding from several sources to achieve efficiency and avoid duplicating services from various providers Schools have identified funds for students in need and at risk as provided by Title 1 and state funded programs, e.g., Readiness to Learn, Twenty First Century Learning Centers, Family Resource Centers, etc.
Indicator 2: **Positive behavior supports**	Interventions are at appropriate level of need Strength based assessments are used for behavior modification Student mentors are used to support struggling students	Therapy made available in school and at home based on the needs of the family Service available on school days/weekends	Clinicians work with classroom teachers as needed and serve as consultants Mental health liaisons assigned to districts from public and private mental health centers	Constant available consultation with teacher Emergent service access is clearly known by all staff Provide tutoring for students Provide one-on-one classroom support.	Strength bases assessments and treatment plan activities will be developed with families whenever possible

Indicator 3: **Mental health services are provided on school grounds.**	Schools have a priority of addressing the needs of the whole student including social, physical, and emotional needs	Community mental health counselors housed at schools Schools to provide space for mental health services	Parents are notified regarding mental health services	A plan for hours of availability of school district space is made in advance	Schools partner with mental health agencies by providing space as needed and negotiated
Indicator 4: **Mental health service access extends beyond the school day.**	Student mental health services are provided in the school building outside normal school operation hours	School buildings remain available after hours and on weekends for community based mental health activities	Community partners are made aware of school building availability	An agreement for hours of availability is made based on the needs for community access	Space provided after school hours. Schools provide janitorial services and supervision of physical space
Indicator 5: **Interagency agreement/MOU is reviewed/revised periodically.**	Agreements focus on the outcomes of health needs of the student/family	Agreements indicate when school building may be available for use by community partners	Negotiate agreements with all community partners	A clear role definition is spelled out in the Interagency agreement	Allow sufficient time for negotiations to occur Indicate origin of all funds that are part of the agreement Indicate what process will be in place regulating how funds will be used and who will be the decision maker(s) for expenditures
Indicator 6: **System in place for sustainability.**	Produce a mission statement that is clear and shows the intent of continuation	School continue to budget funds to continue building operation after hours	Team relationships are the strength that keep the focus of the mission	Community partners recognize the importance of ongoing planning and create time for that purpose	Funding streams and processes remain in place for the duration of the agreement and adjusted as needed

IV. <u>Practice</u>: The mental health providers and schools coordinate data collection and analysis.			
Evidence: (Data)	**Stated Student/Family Outcomes**	**Data Collection System**	**Interagency Agreement/MOU**
Indicator 1: ***Agreement to share data is in place*** Indicator 2: ***Data used to establish benchmarks*** Indicator 3: ***Ongoing data collection is used to identify areas for program improvement***	Agreement keeps student well being as focus Data sources are IEPs, grades, test scores, WASL scores, attendance, behavior indicators (detentions and suspensions), number of students served Parents and community members are utilized to analyze data as a means toward quality improvement	Integration of data system requires interagency agreements that include confidentiality rules Benchmarks are established by community team Parent, teacher and student surveys are used Cross system data collection systems are aligned where possible Each agency uses the data for their own internal quality improvement process	**Agreements are necessary to coordinate collection and analysis.** Benchmarks are included in MOU/Interagency agreement Data collection points are part of agreement. Use data and results/outcomes to encourage replication.

Appendix 6: House Bill 1784 (2003) Selected School/Mental Health Coordination Sites (Grid Chart)

House Bill 1784 (2003)
Selected School/Mental Health Coordination Sites

County	School District(s)	Regional Support Network	Mental Health agency/program
Benton/ Franklin	Kennewick	Greater Columbia Regional Support Network	Three Rivers Wraparound
Clallam	Quillayute Valley	Peninsula Regional Support Network	West End Outreach
Clark	Vancouver and surrounding	Clark County Regional Support Network	Connections Mobile Crisis Assignment Team
Clark	Vancouver and surrounding	Clark County Regional Support Network	School Based Mental Health Support Project (RSN)
Cowlitz	Longview	Southwest Regional Support Network	Lower Columbia Mental Health
Island	Coupeville Oak Harbor	North Sound Regional Support Network	Compass Mental Health
Jefferson	Port Townsend	Peninsula Regional Support Network	Jefferson County Mental Health
King	Renton, Kent	King County Regional Support Network	Valley Cities Counseling
Lewis	Chehalis	Timberlands Regional Support Network	Cascade Mental Health Services
Pierce	Bethel, Franklin Pierce, Puyallup, White River, Orting, Sumner	Pierce County Regional Support Network	Greater Lakes Mental Health
Pierce	Tacoma and surrounding	Pierce County Regional Support Network	Family Support Center Program
Skagit	Burlington-Edison	North Sound Regional Support Network	At Risk Intervention Specialist (A.R.I.S.) Services
Spokane	West Valley	Spokane Regional Support Network	Children's Home Society
Spokane	Spokane	Spokane Regional Support Network	Spokane Mental Health
Stephens	Wellpinit	Northeast Washington Regional Support Network	Department of Health and Human Services
Whitman	Palouse	Greater Columbia Regional Support Network	Palouse River Counseling
Yakima	Yakima	Greater Columbia Regional Support Network	Central Washington Comprehensive Mental Health

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